STONINGTON INSTITUTE

FACSIMILE TRANSMITTAL SHEET

TO: Christine Vogel, Commissioner	FROM: Tim Cimmino
FAX NUMBER: 860-418-7052	DATE: 8/3/05
COMPANY:	TOTAL NO. OF PAGES INCLUDING COVER: 12
PHONE NUMBER:	SENDER'S REFERENCE NUMBER:
RE:	YOUR REFERENCE NUMBER:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

This transmission and all the information contained herein is the property of Stonington Institute, and, as such, it is strictly confidential. It is for the limited use of the named addressee only. If you have received this communication in error, please notify us immediately at 860-439-6000. Thank-you.

234A BANK STREET • NEW LONDON, CT 06320
PHONE: 860-439-6000

Stonington Institute

234A Bank Street
5th Floor
New London, CT
06320

860 / 439.6000
toll-free
800 / 832.1022
fax
860 / 439.6010

August 3, 2005

VIA EXPRESS MAIL
Cristine Vogel, Commissioner
Office of Health Care Access
State of Connecticut
410 Capitol Avenue, MS #13HCA
PO Box 340308
Hartford, CT 06134-0308

Re: Contract Award-Connecticut Judicial Department

Dear Commissioner Vogel:

In June, 2005, Stonington Institute entered into three separate agreements (together, the "Agreements") with the Connecticut Judicial Department-Court Support Services Division for the provision of Adult Behavioral Services (mental health evaluation and treatment). The Agreements were made as a result of Stonington's proposal submitted in response to the Department's RFP #2404B.

The Agreements relate to three service areas: New London, Willimantic and Danielson. In order to provide the requisite services, Stonington must add two service locations as clinics under its Hospital for Mentally Ill license. The two new locations are:

37 Commerce Avenue, Danielson, CT
1491 West Main Street, Willimantic, CT

Accordingly, we are writing to request a determination of whether a Certificate of Need is required in order to add these two locations as satellite clinics under our current license. We have included a completed Form 2020 with this letter in connection with this request.

Very truly yours,

Timothy Crimmins
Director of Business Development

CC: Rose McLellan, DPH

State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020

All persons who are requesting a determination as to whether a CON is required for a proposed project must complete this form. Completed forms should be submitted to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner
Full legal name	**Stonington Behavioral Health, Inc.**
Doing Business As	**Stonington Institute**
Name of Parent Corporation	**Universal Health Services, Inc.**
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	**234A Bank Street** **New London, CT 06320**
Petitioner type (e.g., P for profit and NP for Not for Profit)	**P**
Name of Contact person, including title	**Timothy Crimmins** **Director of Business Development**
Contact person's street mailing address	**Same as above**
Contact person's phone, fax and e-mail address	**860-439-6019 (phone)** **860-439-6008 (fax)**

SECTION II. GENERAL PROPOSAL INFORMATION

a. Proposal/Project Title:

Satellite Clinic Additions

b. Location of proposal (Town including street address):

37 Commerce Avenue, Danielson, CT
1491 West Main Street, Willimantic, CT

c. List all the municipalities this project is intended to serve:

Abington
Ashford
Baillouville
Brooklyn
Canterbury
Chaplin
Danielson
Dayville
East Brooklyn
East Killingly
East Putnam
Eastford
Fabyan
Grosvenor Dale
Hampton
Killingly
Moosup
North Grosvenor Dale
Oneco
Plainfield
Pomfret
Putnam
Putnam Heights
Quinebaug
Rogers
Scotland
South Killingly
South Windham
South Woodstock
Staffordville
Sterling
Thompson
Wauregan
Willimantic
Windham
Woodstock
Amston
Andover
Bolton
Columbia
Coventry
Crystal Lake
Ellington
Hebron
Mansfield
Rockville
Somers
Somersville
South Coventry
Stafford
Stafford Springs
Storrs
Talcottville
Tariffville
Union
Vernon
Vernon Center
Willington

d. Estimated starting date for the project:

October 1, 2005

e. Type of Entity: (Please check *E* for Existing and *P* for Proposed in all the boxes that apply)

E	P		E	P		E	P	
☐	☐	Acute Care Hospital	☐	☐	Imaging Center	☐	☐	Cancer Center
X	☐	Behavioral Health Provider	☐	☐	Ambulatory Surgery Center	☐	☐	Primary Care Clinic
☐	☐	Hospital Affiliate	☐	☐	Other (specify):_____			

SECTION III. EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure/Cost: **$81,000**

b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above)

New Construction/Renovations	$0
Medical Equipment (Purchase)	$0
Imaging Equipment (Purchase)	$0
Non-Medical Equipment (Purchase)	$21,000
Sales Tax	$Included
Delivery & Installation	$Included
Total Capital Expenditure	**$21,000**
Fair Market Value of Leased Equipment (Copiers)	$60,000
Total Capital Cost	**$81,000**

Major Medical and/or imaging equipment acquisition: NONE

Equipment Type	Name	Model	Number of Units	Cost per unit

Note: Provide copy of contract with vendor for medical equipment.

c. Type of financing or funding source:

X	Operating Funds	☐	Lease Financing	☐	Conventional Loan
☐	Charitable Contributions	☐	CHEFA Financing	☐	Grant Funding
☐	Funded Depreciation	☐	Other (specify): _____		

SECTION IV. PROPOSAL DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

See attached

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Will you be charging a facility fee?
4. Who is the current population served and who is the target population to be served?
5. Who will be providing the service?
6. Who are the payers of this service?

SECTION V. AFFIDAVIT

Applicant: Stonington Behavioral Health, Inc. d/b/a Stonington Institute

Project Title: Satellite Clinic Additions

I, Michael Stramiello, CFO of Stonington Behavioral Health, Inc., being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge, and that Stonington Institute complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature

8/2/05
Date

Subscribed and sworn to before me on August 2, 2005.

Commissioner of Superior Court

Section IV Statement
Stonington Institute
Satellite Clinic Additions

1. Stonington Institute currently offers outpatient, day and evening mental health and substance abuse treatment at sites in Waterford and Groton. These sites are licensed as satellite clinics under our Department of Public Health, Hospital for Mentally Ill Persons license (License No. 0071), a copy of which is attached to this Determination Form (the "License").

2. In June, 2005, Stonington Institute entered into three separate agreements (together, the "Agreements") with the Connecticut Judicial Department-Court Support Services Division for the provision of Adult Behavioral Services (mental health evaluation and outpatient treatment).

3. The Agreements were executed as a result of Stonington's successful proposal submitted in response to the Department's RFP #2404B. A copy of the fully-executed face sheets with respect to each of the respective Agreements are attached.

4. The Agreements relate to three service areas: New London, Willimantic and Danielson. Stonington is capable of providing the New London area services at its existing clinic locations. In order to provide the requisite outpatient services for Willimantic and Danielson, Stonington must add two service locations as clinics under its License. The two new locations are:

   37 Commerce Avenue, Danielson, CT

   1491 West Main Street, Willimantic, CT

5. Patients will be referred to the programs by the Judicial Department, Court Support Services Division. Payer sources will include the Judicial Department (as payer of last resort) as well as third party insurance plans insuring individuals referred to the programs. The Agreements establish reimbursement rates for Judicial Department payments and rates for third party plans are established in existing contracts with payers held by Stonington.

6. The outpatient services proposed for the two additional sites are services Stonington is currently licensed to provide. The capital cost is below the statutory threshold. The evaluation and treatment services will be billed and reimbursed at existing rates under third party payer agreements and under contracted rates under the Agreements.

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0071

Hospital for Mentally Ill Persons

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Stonington Behavioral Health, Inc. of New London, CT, d/b/a Stonington Institute is hereby license maintain and operate a Hospital for Mentally Ill Persons.

Stonington Institute is located at 75 Swantown Hill Road, North Stonington, CT 06359

The maximum number of beds shall not exceed at any time:
4 Licensed Bed

This license expires **September 30, 2006** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, December 13, 2004.

Satellites
Day/Evening Treatment, 86 Boston Post Road, Waterford, CT
Day/Evening Treatment, 333 Long Hill Road, Groton, CT
Day/Evening Treatment, 428 Long Hill Road, Groton, CT
Day/Evening/Residential & Outpatient Intensive Tmt, 75 Swantown Hill Road, North Stonington, CT
Outpatient Substance Abuse, 83 Boston Post Road, Waterford, CT

J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H.,
Commissioner

CONNECTICUT JUDICIAL BRANCH

35AGREEMENT
2404B - Adult Behavioral Health

This Agreement is between:
State of Connecticut Judicial Branch
Acting herein by its
Court Support Services Division
(Hereinafter: Judicial Branch)

And **Stonington Institute**
(Hereinafter: Contractor)

This Agreement is made as a result of the Contractor's proposal submitted in response to the Request for Proposal (RFP) **#2404B**. The location(s) area awarded is: **Danielson.**

The Judicial Branch and the Contractor agree that the Contractor shall render services to the Judicial Branch as described in **EXHIBIT A** of this Agreement, (unless such description conflicts with any of the terms and conditions of this Agreement in which event the terms and conditions of this Agreement shall supercede said description) according to all the terms and conditions of this Agreement and that the Judicial Branch shall pay the Contractor for these services according to the terms contained in this Agreement.

The terms and conditions set forth herein and, where applicable, as incorporated under the Connecticut Judicial Branch purchase order, constitute the entire agreement between the parties hereto and supersede all previous agreements, promises or representations whether written or oral. This Agreement may not be changed, altered or modified except by an instrument in writing signed by a duly authorized representative of both parties.

The Contractor and the Judicial Branch agree to all the terms and conditions stated within this Agreement.

FOR:
State of Connecticut
Judicial Branch

By: WILLIAM H. CARBONE,
EXECUTIVE DIRECTOR
Court Support Services Division
Duly Authorized

7-11-05
DATE

FOR CONTRACTOR:

WILLIAM A. ANISKOVICH
CEO

6/29/05
DATE

RECEIVED
COURT SUPPORT
SERVICES DIVISION
JUL 11 2 41 PM '05

CONNECTICUT JUDICIAL BRANCH

AGREEMENT
2404B - Adult Behavioral Health

This Agreement is between:
State of Connecticut Judicial Branch
Acting herein by its
Court Support Services Division
(Hereinafter: Judicial Branch)

And **Stonington Institute**
(Hereinafter: Contractor)

This Agreement is made as a result of the Contractor's proposal submitted in response to the Request for Proposal (RFP) **#2404B**. The location(s) area awarded is: **Willimantic.**

The Judicial Branch and the Contractor agree that the Contractor shall render services to the Judicial Branch as described in **EXHIBIT A** of this Agreement, (unless such description conflicts with any of the terms and conditions of this Agreement in which event the terms and conditions of this Agreement shall supercede said description) according to all the terms and conditions of this Agreement and that the Judicial Branch shall pay the Contractor for these services according to the terms contained in this Agreement.

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The Contractor and the Judicial Branch agree to all the terms and conditions stated within this Agreement.

FOR:
State of Connecticut
Judicial Branch

By: WILLIAM H. CARBONE,
EXECUTIVE DIRECTOR
Court Support Services Division
Duly Authorized

7-11-05
DATE

FOR CONTRACTOR:

WILLIAM A. ANISKOVICH
CEO

6/29/05
DATE

CONNECTICUT JUDICIAL BRANCH

36 AGREEMENT
2404B - Adult Behavioral Health

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State of Connecticut Judicial Branch
Acting herein by its
Court Support Services Division
(Hereinafter: Judicial Branch)

And **Stonington Institute**
(Hereinafter: Contractor)

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The Contractor and the Judicial Branch agree to all the terms and conditions stated within this Agreement.

FOR:
State of Connecticut
Judicial Branch

By: WILLIAM H. CARBONE,
EXECUTIVE DIRECTOR
Court Support Services Division
Duly Authorized

7-11-05
DATE

FOR CONTRACTOR:

WILLIAM A. ANISKOVICH
CEO

6/29/05
DATE

RECEIVED
COURT SUPPORT
SERVICES DIVISION
JUL 11 2 44 PM '05

Stonington Institute

234A Bank Street
5th Floor
New London, CT
06320

860 / 439.6000
toll-free
800 / 832.1022
fax
860 / 439.6010

August 3, 2005

VIA EXPRESS MAIL
Cristine Vogel, Commissioner
Office of Health Care Access
State of Connecticut
410 Capitol Avenue, MS #13HCA
PO Box 340308
Hartford, CT 06134-0308

Re: Contract Award-Connecticut Judicial Department

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1491 West Main Street, Willimantic, CT

Accordingly, we are writing to request a determination of whether a Certificate of Need is required in order to add these two locations as satellite clinics under our current license. We have included a completed Form 2020 with this letter in connection with this request.

Very truly yours,

Timothy Crimmins
Director of Business Development

CC: Rose McLellan, DPH

State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020

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SECTION I. PETITIONER INFORMATION

If more than 2 Petitioners, please attach a separate sheet of paper and provide additional information in the format below:

	Petitioner
Full legal name	**Stonington Behavioral Health, Inc.**
Doing Business As	**Stonington Institute**
Name of Parent Corporation	**Universal Health Services, Inc.**
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	**234A Bank Street New London, CT 06320**
Petitioner type (e.g., P for profit and NP for Not for Profit)	**P**
Name of Contact person, including title	**Timothy Crimmins Director of Business Development**
Contact person's street mailing address	**Same as above**
Contact person's phone, fax and e-mail address	**860-439-6019 (phone) 860-439-6008 (fax)**

SECTION II. GENERAL PROPOSAL INFORMATION

a. Proposal/Project Title:

Satellite Clinic Additions

b. Location of proposal (Town including street address):

37 Commerce Avenue, Danielson, CT
1491 West Main Street, Willimantic, CT

c. List all the municipalities this project is intended to serve:

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Ballouville
Brooklyn
Canterbury
Chaplin
Danielson
Dayville
East Brooklyn
East Killingly
East Putnam
Eastford
Fabyan
Grosvenor Dale
Hampton
Killingly
Moosup
North Grosvenor Dale
Oneco
Plainfield
Pomfret
Putnam
Putnam Heights
Quinebaug
Rogers
Scotland
South Killingly
South Windham
South Woodstock
Staffordville
Sterling
Thompson
Wauregan
Willimantic
Windham
Woodstock
Amston
Andover
Bolton
Columbia
Coventry
Crystal Lake
Ellington
Hebron
Mansfield
Rockville
Somers
Somersville
South Coventry
Stafford
Stafford Springs
Storrs
Talcottville
Tariffville
Union
Vernon
Vernon Center
Willington

d. Estimated starting date for the project:

October 1, 2005

e. Type of Entity: (Please check *E* for Existing and *P* for Proposed in all the boxes that apply)

E	P		E	P		E	P	
☐	☐	Acute Care Hospital	☐	☐	Imaging Center	☐	☐	Cancer Center
X	☐	Behavioral Health Provider	☐	☐	Ambulatory Surgery Center	☐	☐	Primary Care Clinic
☐	☐	Hospital Affiliate	☐	☐	Other (specify):_____			

SECTION III. EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure/Cost: **$81,000**

b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above)

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Non-Medical Equipment (Purchase)	$21,000
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Total Capital Cost	**$81,000**

Major Medical and/or imaging equipment acquisition: NONE

Equipment Type	Name	Model	Number of Units	Cost per unit

Note: Provide copy of contract with vendor for medical equipment.

c. Type of financing or funding source:

X	Operating Funds	☐	Lease Financing	☐	Conventional Loan
☐	Charitable Contributions	☐	CHEFA Financing	☐	Grant Funding
☐	Funded Depreciation	☐	Other (specify): _____		

SECTION IV. PROPOSAL DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

See attached

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Will you be charging a facility fee?
4. Who is the current population served and who is the target population to be served?
5. Who will be providing the service?
6. Who are the payers of this service?

SECTION V. AFFIDAVIT

Applicant: Stonington Behavioral Health, Inc. d/b/a Stonington Institute

Project Title: Satellite Clinic Additions

I, Michael Stramiello, CFO of Stonington Behavioral Health, Inc., being duly sworn, depose and state that the information provided in this CON Determination form is true and accurate to the best of my knowledge, and that Stonington Institute complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature

8/2/05
Date

Subscribed and sworn to before me on August 2, 2005.

Commissioner of Superior Court

Section IV Statement
Stonington Institute
Satellite Clinic Additions

1. Stonington Institute currently offers outpatient, day and evening mental health and substance abuse treatment at sites in Waterford and Groton. These sites are licensed as satellite clinics under our Department of Public Health, Hospital for Mentally Ill Persons license (License No. 0071), a copy of which is attached to this Determination Form (the "License").

2. In June, 2005, Stonington Institute entered into three separate agreements (together, the "Agreements") with the Connecticut Judicial Department-Court Support Services Division for the provision of Adult Behavioral Services (mental health evaluation and outpatient treatment).

3. The Agreements were executed as a result of Stonington's successful proposal submitted in response to the Department's RFP #2404B. A copy of the fully-executed face sheets with respect to each of the respective Agreements are attached.

4. The Agreements relate to three service areas: New London, Willimantic and Danielson. Stonington is capable of providing the New London area services at its existing clinic locations. In order to provide the requisite outpatient services for Willimantic and Danielson, Stonington must add two service locations as clinics under its License. The two new locations are:

   37 Commerce Avenue, Danielson, CT

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5. Patients will be referred to the programs by the Judicial Department, Court Support Services Division. Payer sources will include the Judicial Department (as payer of last resort) as well as third party insurance plans insuring individuals referred to the programs. The Agreements establish reimbursement rates for Judicial Department payments and rates for third party plans are established in existing contracts with payers held by Stonington.

6. The outpatient services proposed for the two additional sites are services Stonington is currently licensed to provide. The capital cost is below the statutory threshold. The evaluation and treatment services will be billed and reimbursed at existing rates under third party payer agreements and under contracted rates under the Agreements.

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0071

Hospital for Mentally Ill Persons

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Stonington Behavioral Health, Inc. of New London, CT, d/b/a Stonington Institute is hereby license maintain and operate a Hospital for Mentally Ill Persons.

Stonington Institute is located at 75 Swantown Hill Road, North Stonington, CT 06359

The maximum number of beds shall not exceed at any time:
4 Licensed Bed

This license expires **September 30, 2006** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, December 13, 2004.

Satellites
Day/Evening Treatment, 86 Boston Post Road, Waterford, CT
Day/Evening Treatment, 333 Long Hill Road, Groton, CT
Day/Evening Treatment, 428 Long Hill Road, Groton, CT
Day/Evening/Residential & Outpatient Intensive Tmt, 75 Swantown Hill Road, North Stonington, CT
Outpatient Substance Abuse, 83 Boston Post Road, Waterford, CT

J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H.,
Commissioner

CONNECTICUT JUDICIAL BRANCH

35 AGREEMENT
2404B - Adult Behavioral Health

This Agreement is between:

State of Connecticut Judicial Branch
Acting herein by its
Court Support Services Division
(Hereinafter: Judicial Branch)

And **Stonington Institute**
(Hereinafter: Contractor)

This Agreement is made as a result of the Contractor's proposal submitted in response to the Request for Proposal (RFP) **#2404B**. The location(s) area awarded is: **Danielson.**

The Judicial Branch and the Contractor agree that the Contractor shall render services to the Judicial Branch as described in **EXHIBIT A** of this Agreement, (unless such description conflicts with any of the terms and conditions of this Agreement in which event the terms and conditions of this Agreement shall supercede said description) according to all the terms and conditions of this Agreement and that the Judicial Branch shall pay the Contractor for these services according to the terms contained in this Agreement.

The terms and conditions set forth herein and, where applicable, as incorporated under the Connecticut Judicial Branch purchase order, constitute the entire agreement between the parties hereto and supersede all previous agreements, promises or representations whether written or oral. This Agreement may not be changed, altered or modified except by an instrument in writing signed by a duly authorized representative of both parties.

The Contractor and the Judicial Branch agree to all the terms and conditions stated within this Agreement.

FOR:
State of Connecticut
Judicial Branch

By: WILLIAM H. CARBONE,
EXECUTIVE DIRECTOR
Court Support Services Division
Duly Authorized

7-11-05
DATE

FOR CONTRACTOR:

WILLIAM A. ANISKOVICH
CEO

6/29/05
DATE

RECEIVED
COURT SUPPORT
SERVICES DIVISION
JUL 11 2 42 PM '05

CONNECTICUT JUDICIAL BRANCH

AGREEMENT
2404B - Adult Behavioral Health

This Agreement is between:
State of Connecticut Judicial Branch
Acting herein by its
Court Support Services Division
(Hereinafter: Judicial Branch)

And **Stonington Institute**
(Hereinafter: Contractor)

This Agreement is made as a result of the Contractor's proposal submitted in response to the Request for Proposal (RFP) **#2404B**. The location(s) area awarded is: **Willimantic.**

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The Contractor and the Judicial Branch agree to all the terms and conditions stated within this Agreement.

FOR:
State of Connecticut
Judicial Branch

By: WILLIAM H. CARBONE,
EXECUTIVE DIRECTOR
Court Support Services Division
Duly Authorized

7-11-05
DATE

FOR CONTRACTOR:

WILLIAM A. ANISKOVICH
CEO

6/29/05
DATE

CONNECTICUT JUDICIAL BRANCH

-36 AGREEMENT
2404B - Adult Behavioral Health

This Agreement is between:
State of Connecticut Judicial Branch
Acting herein by its
Court Support Services Division
(Hereinafter: Judicial Branch)

And **Stonington Institute**
(Hereinafter: Contractor)

This Agreement is made as a result of the Contractor's proposal submitted in response to the Request for Proposal (RFP) **#2404B**. The location(s) area awarded is: **New London.**

The Judicial Branch and the Contractor agree that the Contractor shall render services to the Judicial Branch as described in **EXHIBIT A** of this Agreement, (unless such description conflicts with any of the terms and conditions of this Agreement in which event the terms and conditions of this Agreement shall supercede said description) according to all the terms and conditions of this Agreement and that the Judicial Branch shall pay the Contractor for these services according to the terms contained in this Agreement.

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FOR:
State of Connecticut
Judicial Branch

By: WILLIAM H. CARBONE,
EXECUTIVE DIRECTOR
Court Support Services Division
Duly Authorized

7-11-05
DATE

FOR CONTRACTOR:

WILLIAM A. ANISKOVICH
CEO

6/29/05
DATE

RECEIVED
COURT SUPPORT
SERVICES DIVISION
JUL 11 2 44 PM '05

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 8, 2005

Timothy Crimmins
Director of Business Development
Stonington Institute
234A Bank Street
New London, CT 06320

RE: Certificate of Need Application Forms, Docket Number 05-30563-CON
Stonington Institute
Proposal to provide Adult Behavioral Services by Contract to CSSD

Dear Mr. Crimmins:

Enclosed are the application forms, a paper copy and an electronic copy on diskette, for Stonington Institute's Certificate of Need ("CON") proposal for the Proposal to provide Adult Behavioral Services by contract to CSSD with an associated capital expenditure of $81,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between October 2, 2005, and December 1, 2005.

When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and five hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests that an electronic copy be in submitted in MS Word format and the scanned copy be submitted in Adobe format. Please submit the Financial Attachment and other data as appropriate in MS Excel format.

The analyst assigned to the CON application is Laurie Greci. Please feel free to contact him/her at (860) 418-7001, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, Not Applicable will be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than October 2, 2005, and may be submitted no later than December 1, 2005. The Analyst assigned to your application is Laurie Greci and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number:	05-30563-CON
Applicant(s) Name:	Stonington Institute
Contact Person: **Contact Title:**	Timothy Crimmins Director of Business Development Stonington Institute
Contact Address:	234A Bank Street New London, CT 06320
Project Location:	Danielson and Willimantic
Project Name:	Proposal to provide Adult Behavioral Services by contract to State of Connecticut, Department of Justice, Court Support Services Division ("CSSD")
Type proposal:	Section 19a-638
Est. Capital Expenditure: *(Note: Does not include Capitalized Financing Costs)*	$81,000

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed expansion or new service will augment or replace? Please list.

Augment: _____

_____

Replace: _____

_____

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

If "No" is checked, please provide an explanation.

4. Clear Public Need

A. Explain how it was determined there was a need for the proposal in your service area.

i) Provide the following information:
   a) Primary and secondary service area towns
   b) If existing facility/service, the unit of service (i.e. procedure, scan, visit, etc.) for the past three fiscal years by service area town
   c) If new facility/service, the population to be served, including the number of individuals to receive the proposed service(s). Include demographic Information, as appropriate.
   d) Scheduling backlogs in service area
   e) Travel distance from proposed site to service area towns
   f) Hours of operation of existing/proposed service

ii) Identify the existing providers of the proposed service in your service area.

iii) Provide the information as outlined in the following table concerning the existing providers' (in the Applicant(s) PSA) current operations:

Description of Service[1]	Provider Name and Location	Hours and Days of Operation[2]	Current Utilization[3]

[1] List service levels provided.
[2] Specify days of the week and start and end time for each day.
[3] Report volume by patient or visits for the most recent 12 month period, if known.

iv) What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

v) Provide the units of service projected for the first three years of operation of the proposed service. **Include the derivation/calculation.**

B. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

If you checked other than None of the above, please provide an explanation.

C. Provide copies of any of the following plans, studies or reports related to your proposal:

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

5. Quality Measures

A. If the proposal is for a new technology or procedure, have all appropriate agencies approved the proposed procedure (e.g., FDA etc.)?

☐ Yes ☐ No ☐ Not Applicable

If "No", please provide an explanation.

B. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

☐ American College of Cardiology ☐ National Committee for Quality Assurance ☐ Public Health Code & Federal Corollary

☐ National Association of Child Bearing Centers ☐ American College of Obstetricians & Gynecologists ☐ American College of Surgeons

☐ Report of the Inter-Mental Society Council for Services Administration Radiation Oncology ☐ American College of Radiology ☐ Substance Abuse and Health

☐ Other: Specify _____

C. Describe in detail how the Applicant plans to meet the each of the guidelines checked off above.

D. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, therapists, counselors, etc., related to the proposal and a copy of their Curriculum Vitae.

Note: For physicians, please provide a list of hospitals where the physicians have admitting privileges.

E. Provide a copy of the most recent inspection reports and/or certificate for your facility:

- ☐ DPH
- ☐ JCAHO
- ☐ Fire Marshall Report
- ☐ Other States Health Dept. Reports (new out-of-state providers)
- ☐ AAAHC
- ☐ AAAASF
- ☐ Other: _____

Note: Above referenced acronyms are defined below. [1]

F. Provide a copy of the following (as applicable):

- ☐ A copy of the related Quality Assurance plan
- ☐ Protocols for service (new service only)
- ☐ Patient Selection Criteria/Intake form

6. Improvements to Productivity and Containment of Costs

In the past year has your facility undertaken any of the following activities to improve productivity and contain costs?

- ☐ Energy conservation
- ☐ Group purchasing
- ☐ Reengineering
- ☐ None of the above
- ☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)
- ☐ Other (identify)_____

[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

7. Miscellaneous

A. Will this proposal result in new (or a change to) your teaching or research responsibilities?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

B. Are there any characteristics of your patient/physician mix that makes your proposal unique?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

C. Provide the following licensing information:

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

ii) The DPH licensure category you are seeking.

iii) If not applicable, please explain why.

9. Financial Information

A. Type of ownership: (Please check off all that apply)

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Provide the following financial information:

i) Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the Applicant is a hospital that has filed its most recently completed fiscal year audited financial statements, the Applicant may reference that filing for this proposal.

ii) If the Applicant is a hospital, provide the total current assets balance as of the date of submission of this application.

iii) If the Applicant is a hospital, provide a copy of the most recently completed internal monthly financial statements, including utilization volume totals to date. (For new service only)

iv) If the Applicant is a hospital, provide the name and units of service for the new cost center to be established for the proposal.

v) If the Applicant is not a hospital, please submit the Applicant's audited financial statements for the most recently completed fiscal year. If the Applicant has no audited financial statements, please submit a compilation report or an unaudited Balance Sheet and Statement of Operations for the most recently completed fiscal year. These statements should be externally prepared and submitted on the preparer's letterhead.

vi) Identify the entity that will be billing for the proposed service.

10. Major Cost Components/Total Capital Expenditure

Submit a final version of all capital expenditures/costs as follows:

Medical Equipment (Purchase)	$
Major Medical Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$**
Medical Equipment (Lease (FMV))	$
Major Medical Equipment (Lease (FMV)	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	**$**
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	$

* Provide an itemized list of all non-medical equipment.

13. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:

Source and amount:

Operating Funds Source/Entity Name Available Funds	$ _____ _____ _____
Contributions	$ _____
Funded depreciation	$ _____
Other	$ _____

☐ Grant:

Amount of grant	$ _____
Funding institution/ entity	_____

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	$ _____
CON Proposed debt financing	$ _____
Interest rate	_____ %
Monthly payment	$ _____
Term	_____ Years
Debt service reserve fund	$ _____

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	$ _____
CON Proposed lease financing	$ _____
Fair market value of leased assets at lease inception	$ _____
Interest rate	_____ %
Monthly payment	$ _____
Term	_____ Years

☐ Other financing alternatives:

Amount	$ _____
Source (e.g., donated assets, etc.)	_____

B. Please provide copies of the following, if applicable:
   i. Letter of interest from the lending institution,
   ii. Letter of interest from CHEFA,
   iii. Amortization schedule (if not level amortization payments),
   iv. Lease agreement.

14. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

A.2. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

B. Does the Applicant(s) have Tax Exempt Status? ☐ Yes ☐ No

C. Provide the following for the financial and statistical projections:

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.

ii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

iii) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

iv) Provide a copy of the rate schedule for the proposed service.

v) Describe how this proposal is cost effective.

13. B (i). Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and if applicable, volume statistics without, incremental to and with the proposal in the following reporting format:

Total Facility: Description	FY Actual Results	FY Projected W/out Project	FY Projected Incremental	FY Projected With Project	FY Projected W/out Project	FY Projected Incremental	FY Projected With Project	FY Projected W/out Project	FY Projected Incremental	FY Projected With Project
Revenue from Operations				$0			$0			$0
Non-Operating Revenue				$0			$0			$0
Total Revenue:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Operating Expenses				$0			$0			$0
Income before provision for income taxes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Provision for income taxes				$0			$0			$0
Net Income	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, beginning of year		$0	$0	$0	$0	$0	$0	$0	$0	$0
Retained earnings, end of year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

*Volume Statistics:

*Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

GENERAL AFFIDAVIT

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 5, 2005

Timothy Crimmins
Director of Business Development
Stonington Institute
234A Bank Street
New London, CT 06320

Re: Letter of Intent, Docket Number 05-30563
Stonington Institute
Proposal to provide Adult Behavioral Services by contract to CSSD
Notice of Letter of Intent

Dear Mr. Crimmins:

On August 3, 2004, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Stonington Institute ("Applicant") to add two satellite locations for out patient services for patients referred by CSSD , at a total capital expenditure of $81,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Chronicle* pursuant to Section 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

KRM:LKG:dpd

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 8, 2005

Requisition # HCA06-041
FAX #: (860) 423-7641

The Chronicle
One Chronicle Road
Box 148
Willimantic, CT 06226-0148

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than Friday, August 12, 2005.

Please fax evidence that the legal notice was published by the date requested above to (860) 418-7053. In addition, please send the original legal notice (full tear sheet is required) with the invoice.

If there are any questions regarding this legal notice, please contact Laurie Greci at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:LKG:dpd

c: Kathy Howe, OHCA

The Chronicle
Docket Number 05-30563

Letter of Intent
August 8, 2005

PLEASE INSERT THE FOLLOWING:

Pursuant to Section 19a-638 of the Connecticut General Statutes, the Office of Health Care Access ("OHCA") has received a Letter of Intent to file the following Certificate of Need application:

Applicant:	Stonington Institute
Towns:	Danielson and Willimantic
Docket Number:	05-30563-LOI
Proposal:	Proposes to add two satellite locations for out patient services for patients referred by CSSD
Total Capital Expenditure:	$81,000

The Applicant may file its Certificate of Need application between October 2, 2005 and December 1, 2005. Interested persons are invited to submit written comments to OHCA regarding the Letter of Intent or the Certificate of Need application, when it is submitted by the Applicant. Such comments should be directed to:

Cristine A. Vogel
Commissioner
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent may be obtained from OHCA at the standard copy charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant. A copy of the Certificate of Need application may then be obtained from OHCA at the standard copy charge.

Confirmation Report – Memory Send

Time : Aug-08-2005 14:21
Tel line : 8604187053
Name : OFFICE OF HEALTHCARE

Job number	:	877
Date	:	Aug-08 14:20
To	:	98604237641
Document pages	:	002
Start time	:	Aug-08 14:20
End time	:	Aug-08 14:21
Pages sent	:	002
Status	:	OK

Job number : 877 *** SEND SUCCESSFUL ***

M. Jodi Rell
Governor

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

Cristine A. Vogel
Commissioner

August 8, 2005

Requisition # HCA06-041
FAX #: (860) 423-7641

The Chronicle
One Chronicle Road
Box 148
Willimantic, CT 06226-0148

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KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Certificate of Need Supervisor

Attachment

KRM:LKG:dpd

c: Kathy Howe, OHCA

An Equal Opportunity Employer
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308
Telephone: (860) 418-7001 • Toll free (800) 797-9688
Fax: (860) 418-7053